ORAL ARGUMENT NOT YET SCHEDULED

No. 19-5125

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

STATE OF NEW YORK, *et al.*

Plaintiffs-Appellees,

v.

U.S. DEPARTMENT OF LABOR, *et al.*

Defendants-Appellants.

On Appeal from the United States District Court
for the District of Columbia
No. 1:18-cv-1747-JDB

BRIEF FOR AMICI CURIAE FAMILIES USA, NATIONAL PARTNERSHIP FOR WOMEN AND FAMILIES, NATIONAL WOMEN'S LAW CENTER, NATIONAL EMPLOYMENT LAW PROJECT, NATIONAL HEALTH LAW PROGRAM, UNITED HOSPITAL FUND, AND PUBLIC CITIZEN SUPPORTING APPELLEES AND AFFIRMANCE

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July 22, 2019

CERTIFICATE AS TO PARTIES, RULINGS, RELATED CASES, FILING OF A SEPARATE BRIEF, AND RULE 26.1 DISCLOSURE

As required by Circuit Rules 26.1, 28(a)(1), and 29(d), and Federal Rule of Appellate Procedure 26.1, counsel for amici curiae hereby certify as follows:

1. Parties and Amici

Except for the following, all parties, intervenors, and amici appearing in the lower court and this Court are listed in the certificates to the Opening Brief of Appellants U.S. Department of Labor, *et al.*, and the Brief for Appellees New York, *et al.*

The amici joining this brief are: Families USA, National Partnership for Women and Families, National Women's Law Center, National Employment Law Project, National Health Law Program, United Hospital Fund, and Public Citizen.

The following Health Care Policy History Scholars have filed an amicus brief supporting appellees (titles omitted): Henry J. Aaron, Linda J. Blumberg, Andrea Louise Campbell, Daniel Carpenter, Sabrina Corlette, David Cutler, Judith Feder, Steven Davidson, Doug Elmendorf, Robert Field, Sherry Glied, Colin Gordon, Colleen M. Grogan, Jacob S. Hacker, Mark A. Hall, John Holahan, David K. Jones, Timothy Stoltzfus Jost, Miriam Laugesen, Theodore Marmor, Rick Mayes, Jonathan Oberlander, Thomas R.

Oliver, Dania Palanker, Mark Peterson, Harold Pollack, Sara Rosenbaum, William Sage, Mark Schlesinger, David Shactman, David Barton Smith, Michael Sparer. JoAnn Volk, Joseph White, Christen Linke Young, Stephen Zuckerman.

The following members of Congress have filed an amicus brief supporting appellees: Rep. Nancy Pelosi, Rep. Steny H. Hoyer, Rep. James E. Clyburn, Rep. Ben Ray Luján, Rep. Hakeem Jeffries, Rep. Katherine Clark, Rep. Robert C. "Bobby" Scott, Rep. Frank Pallone, Jr., Rep. Jerrold Nadler, and Rep. Richard E. Neal.

2. Rulings Under Review

References to the district court decision under review appear in the certificates to the Opening Brief of Appellants U.S. Department of Labor, *et al.*, and the Brief of Appellees New York, *et al.*

3. Related Cases

A description of related cases appears in the certificate to the Opening Brief of Appellants U.S. Department of Labor, *et al.*, and the Brief of Appellees New York, *et al.*

4. Separate Brief

Amici joining this brief have filed a separate brief from the other amici that intend to file briefs supporting plaintiffs-appellees. A single amicus

curiae brief is not practicable in this case because amici's brief addresses aspects of the issues posed by this appeal that the other amici do not intend to address. Specifically, this brief details how the Department of Labor (DOL) impermissibly interpreted two statutes in ways that harm small-business employees and their dependents—and will particularly hurt women, the elderly, individuals with disabilities, and others who rely on access to affordable and comprehensive health care. Specifically, DOL interpreted the Employee Retirement Income Security Act and title XXVII of the Public Health Service Act in ways that undermine the market reforms that Congress enacted in the Patient Protection and Affordable Care Act (ACA). As organizations dedicated to protecting and promoting comprehensive and affordable health care, amici offer a perspective on DOL's actions that differ from the perspective offered by other amici. Amici understand that other amici's arguments will focus on other aspects of DOL's rule that reflect their concerns and expertise. *See* D.C. Cir. R. 29(d).

5. Rule 26.1 Disclosure.

Families USA is a nonprofit organization that has not issued shares or debt securities to the public and has no parent companies. No publicly held company has any form of ownership interest in Families USA. The general purpose of Families USA is to advocate on behalf of the interests of health

care consumers, including consumers' access to comprehensive, affordable health care.

National Partnership for Women and Families (NPWF) is a nonprofit organization that has not issued shares or debt securities to the public and has no parent companies. No publicly held company has any form of ownership interest in NPWF. The general purpose of NPWF is to promote fairness in the workplace, reproductive health and rights, and access to affordable, quality health care that meets women's needs and reduces disparities in health outcomes.

National Women's Law Center (NWLC) is a nonprofit legal advocacy organization that has not issued shares or debt securities to the public and has no parent companies. No publicly held company has any form of ownership interest in NWLC. NWLC is dedicated to the advancement and protection of women's legal rights and opportunities. NWLC focuses on issues of key importance to women and their families, including economic security, employment, education, health, and reproductive rights, with special attention to the needs of low-income women and those who face multiple and intersecting forms of discrimination. NWLC has participated as amicus in numerous cases explaining the importance of the ACA to women, including briefs on behalf of itself and dozens of additional organizations

before the U.S. Supreme Court in *King v. Burwell*, 135 S. Ct. 2480 (2015), and *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012).

The National Employment Law Project (NELP) is a nonprofit organization that has not issued shares or debt securities to the public and has no parent companies. No publicly held company has any form of ownership interest in NELP. The general purpose of NELP is to ensure that America upholds the promise of opportunity and economic security, including access to high quality affordable healthcare, for all its workers, especially low-wage workers.

National Health Law Program (NHeLP) is a nonprofit organization that has not issued shares or debt securities to the public and has no parent companies. No publicly held company has any form of ownership interest in NHeLP. The general purpose of NHeLP is to give a voice to low-income individuals and families in federal and state policy making, promote the rights of patients in emerging managed-care health care systems that too often put profits over people, and advocate for a health care system that will ensure all people have access to quality and comprehensive health care.

United Hospital Fund (UHF) is a nonprofit organization that has not issued shares or debt securities to the public and has no parent companies.

No publicly held company has any form of ownership interest in UHF. The general purpose of UHF is to build a more effective health care system for New Yorkers, one that is affordable and accessible, provides a better patient experience and the highest quality of care, and achieves optimal outcomes—with a special focus on the needs of the most vulnerable.

Public Citizen is a nonprofit organization that has not issued shares or debt securities to the public and has no parent companies. No publicly held company has any form of ownership interest in Public Citizen. The general purpose of Public Citizen is to advocate for the interests of consumers and the general public on a range of issues, including the issue of expanding consumer access to secure and affordable health care.

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GLOSSARY

ACA	Patient Protection and Affordable Care Act
AHP	Association Health Plans
DOL	Department of Labor
ERISA	Employee Retirement Income Security Act
HHS	Department of Health and Human Services
PHS Act	Public Health Service Act

INTEREST OF AMICI CURIAE[1]

Amici curiae joining this brief are Families USA, National Partnership for Women and Families, National Women's Law Center, National Employment Law Project, National Health Law Program, United Hospital Fund, and Public Citizen. Each amicus is a nonprofit organization that works to ensure that individuals have access to health-care coverage that is affordable and comprehensive.

Each amicus filed comments in the underlying rulemaking urging the Department of Labor (DOL) not to adopt the rule under review. The various communities that amici serve—including women and families, the elderly, persons with disabilities, and other individuals that rely on the access to affordable and comprehensive health care for financial security and personal health—have benefitted from the individual and small-group market reforms that Congress enacted in the Patient Protection and Affordable Care Act (ACA). Amici are concerned that DOL's rule will undermine those reforms by allowing small businesses—both those who have employees and so-called "working owners" who have no employees—to join associations that, by

[1] All parties have consented to the filing of this brief. The brief was not authored in whole or part by counsel for a party. No party or counsel for a party, and no person other than the amicus curiae or its counsel, contributed money intended to fund the brief's preparation or submission.

DOL's design, would offer health coverage outside of the individual and small-group markets.

The effect of DOL's rule, therefore, will be to segment individual and small-group markets in ways that Congress did not intend, which will in turn result in higher prices for insurance, less comprehensive coverage, and discriminatory impacts on individuals who are elderly, female, or live with disabilities, whether they obtain insurance through their employer or on their own. For many vulnerable individuals who rely on access to health care, DOL's rule will result in higher costs, loss of coverage, exclusion for certain conditions, and discriminatory pricing. Amici, therefore, have a significant interest in ensuring that the district court's decision to invalidate DOL's rule is upheld.

STATUTES AND REGULATIONS

The appendix to this brief sets forth statutes and regulations pertinent to the Court's consideration of this case, other than applicable statutes and regulations contained in the Opening Brief of Appellants DOL, *et al.*, and the Brief of Appellees New York, *et al.*

SUMMARY OF ARGUMENT

In *King v. Burwell*, opponents of the ACA sought to exploit ambiguity in the statutory text to undermine the ACA's "interlocking reforms." 135 S. Ct. 2480, 2485 (2015). The Supreme Court rejected that challenge,

recognizing that "in every case we must respect the role of the Legislature, and take care not to undo what it has done." *Id.* at 2496. In this case, DOL seeks to exploit the definition of "employer" in the Employee Retirement Income Security Act of 1974 (ERISA) to undo what Congress has done. This brief focuses on two unlawful actions that DOL took to achieve that end, and the effect of DOL's rule on women, the elderly, individuals with disabilities, and others who rely on the ACA's reforms for access to comprehensive and affordable health care.

I. First, DOL reinterpreted "employer" to collapse the required distinction between "bona fide associations" (who could act as employers under ERISA) and insurance companies. Previously, a bona fide association had to have a purpose, and its members had to share a relationship, that was unrelated to the provision of benefits. DOL's rule removes those requirements. As a result, associations can now exist for the primary purpose of providing health-care coverage through "association health plans" (AHPs), and they can provide that coverage to a large number of disparate and unrelated employers. DOL did not adequately explain how it can maintain the distinction between bona fide associations and insurance companies without those traditional requirements in place.

DOL's control test for associations does not maintain the necessary distinction. That test requires that the association and its health plan be controlled by employers as a class, but it does not ensure that a large association with potentially thousands of disparate and unrelated employer-members can act in the interests of individual employer members, as ERISA requires. DOL's nondiscrimination rule likewise adds nothing to the analysis. Associations retain the ability to discriminate against employers and employees on the basis of age, gender, industry, occupation, group size, or geography; through benefit design; and through membership criteria. This level of discrimination is greater than that in which ACA-regulated insurers in the individual and small-group market can engage. DOL has not explained how allowing associations to engage in more discrimination than insurers makes them less like insurers for purposes of ERISA's definition of "employer."

II. Second, to ensure that these new associations could purchase insurance for their small-business members free of the ACA's reforms applicable to individual and small-group insurance markets, DOL interpreted title XXVII of the Public Health Service (PHS) Act to allow these associations to count their members' employees as their own. In this way, many such associations could be classified as "large employers," which are

not subject to the ACA's individual and small-group market reforms. DOL's interpretation of the PHS Act—a statute outside of its jurisdiction but which cross-references ERISA's definition of "employer"—cannot be reconciled with the text of title XXVII, which defines insurance markets by counting the number of employees "employed" by an employer. DOL has long taken the position that associations do not employ their members' employees, and it offered no explanation for its decision to adopt a different view in this case.

To justify its interpretation, DOL relied on a statement by the Department of Health and Human Services (HHS) that associations that fell within the definition of "employer" under DOL's prior interpretation of that term may count their members' employees as their own employees to determine the health-insurance market in which they participate under title XXVII. HHS's statement, however, also failed to grapple with the statutory language of title XXVII and, in any event, did not speak to DOL's new, expansive definition of "employer." And although DOL says that HHS participated as a "consultant" in DOL's rulemaking, HHS cannot delegate its interpretive authority to DOL, nor does consulting with HHS enable DOL to escape its obligation to engage in reasoned decisionmaking.

III. Through these two steps, DOL has created a market for health-care coverage that is irreconcilably at odds with the ACA's market reforms,

resulting in harm to employers and individuals that Congress had intended to protect. In the ACA, Congress sought to protect vulnerable populations in the individual and small-group markets from discrimination in health-care coverage and to enhance their ability to obtain comprehensive health-care coverage at lower prices. By requiring insurers in those markets to cover essential health benefits at adjusted-community-rated prices, Congress barred insurers from skimping on benefits or discriminating on price in an effort to cherry-pick healthier individuals or groups. Congress buttressed these reforms by minimizing risk segmentation in the individual and small-groups markets to prevent adverse selection and keep healthier individuals in the risk pool.

DOL's rule undermines these reforms. DOL regards as a virtue associations' ability to engage in risk-based pricing and to design benefit plans that exclude coverage of essential health benefits. DOL recognized that its rule would increase prices for individual and small-group insurance in ACA-regulated markets, allow discriminatory pricing of AHP coverage on various non-health bases, and leave AHP enrollees with less comprehensive coverage that may not meet their medical needs or provide financial security. DOL justified these effects by pointing to the ACA's treatment of large employers, but it gave no weight to important economic differences between

true large employers and associations of small businesses that DOL has placed in the large-group market. Congress placed small businesses in the individual and small-group markets for a reason, and DOL cannot permissibly use ERISA to undo Congress's work.

"It is implausible that Congress meant the [ACA] to operate" in the way that DOL's rule would permit. *See King*, 135 S. Ct. at 2494. This Court should affirm the district court's judgment invalidating DOL's rule.

ARGUMENT

I. DOL's interpretation of "employer" in ERISA fails to maintain the requisite distinction between employers and health-insurance companies.

For more than four decades, DOL has interpreted ERISA's definition of "employer" to forbid employer associations from acting like insurance companies. DOL has not adequately explained how its new definition of "employer"—reflected in its alternative standard for so-called "bona fide associations"—maintains that distinction.

A. ERISA regulates "employee benefit plans," which include benefit plans "established or maintained" by an "employer." 29 U.S.C. §§ 1001(a), 1002(1) , (2)(A), (3). An "employer" includes "any person acting directly as an employer" or "indirectly in the interest of an employer," including "a group or association of employers acting for an employer in such capacity."

Id. § 1002(5). As appellees' brief explains (at 33–35), the phrase "indirectly in the interest of an employer" limits the types of associations that can validly establish employee benefit plans and serves to distinguish "bona fide associations" from traditional insurance companies. *See also* 83 Fed. Reg. 28,912, 28,913 n.4 (June 21, 2018).

For decades, DOL has used a "facts-and-circumstances approach" to determine whether an association has the requisite employment-based nexus to be considered an "employer" under ERISA. 83 Fed. Reg. at 28,914. Over time, application of that approach yielded certain hard-and-fast rules to distinguish bona fide associations from insurance companies. Unlike an insurance company, a bona fide association was required to have an organizational purpose "unrelated to the provision of benefits." *Id.* Likewise, the association's members were required to "share some commonality and genuine organizational relationship unrelated to the provision of benefits." *Id.* Such members also had to "directly or indirectly[] exercise control over the [employee benefit] program, both in form and substance." *Id.*

B. In the rule under review, DOL removed several of the traditional criteria that distinguished bona fide associations from insurance companies, while adding a new criterion—nondiscrimination—that does nothing to restore the distinction. In making these changes, DOL offered an explanation

that falls well outside "the bounds of reasoned decisionmaking." *Dept. of Commerce v. New York*, 139 S. Ct. 2551, 2569 (2019) (quoting *Baltimore Gas & Elec. Co. v. Natural Res. Def. Council, Inc.*, 462 U.S. 87, 105 (1983)).

DOL's new approach jettisons the requirement that the organizational purpose of a bona fide association be unrelated to the provision of benefits. Now, an association can be an "employer" under ERISA even if its "primary purpose" is "to offer and provide health coverage to its employer members and their employees." 83 Fed. Reg. at 28,962. That primary purpose is indistinguishable from the primary purpose of insurance companies. Recognizing this problem, DOL required that associations maintain a "substantial business purpose unrelated to offering and providing health coverage or other employee benefits." *Id.* at 28,918. But as appellees explain (at 39–40), that requirement imposes no meaningful constraint on associations. Nor does it solve the problem of distinguishing associations from insurance companies because DOL never explains why a traditional insurer could not just as easily satisfy that test. *See* 83 Fed. Reg. at 28,918 n.15.

DOL's rule also removes the requirement that the members of a bona fide association share an organizational relationship unrelated to the provision of benefits. Now, to demonstrate "commonality of interest," it is

sufficient that members be located in the same state or metropolitan area, 83 Fed. Reg. at 28,923–26, or to be part of the same "trade, industry, line of business, or profession," or any "subset" thereof, *id.* at 28,923. The common-geography test, however, does not distinguish associations from insurance companies, which also serve particular geographic areas. *See* Appellees' Br. 43. And neither test imposes any meaningful limits on the ability of associations to rival insurance company in terms of size. In Oklahoma, for example, 347,165 unrelated small businesses could permissibly join a single statewide association health plan under the common-geography test. *See* Oklahoma Amicus Br. 8. And the line-of-business test authorizes nationwide associations whose members are in the same trade or business as determined by "any generally-accepted classification system." 83 Fed. Reg. at 28,923. The commonality-of-interest test is supposed to inform "whether the group or association has a *sufficiently close* economic or representational nexus to the employers and employees that participate in the plan." *Id.* at 28,928 (emphasis added). Under DOL's rule, however, "sufficiently close" means nothing more than the level of closeness found in a standard insurance relationship.

DOL relies heavily on its control test, DOL Br. 32–33, which requires an association and its AHP to be controlled by participating members. 83

Fed. Reg. at 28,919. The control test ensures only that an association will be controlled by employers as a class. By contrast, ERISA's definition of "employer" requires a bona fide association to act in the interest of each individual employer. 29 U.S.C. § 1002(5) (referring to "the interest of an employer"). In a relatively small association, an individual employer has greater control over the association and its AHP and, thus, has a greater ability to ensure that the association acts in its interest. DOL's rule, however, is designed to permit associations of massive size, *see* 83 Fed. Reg. at 28,942–43, which necessarily dilutes the control enjoyed by any individual employer. DOL ignored this concern.

Moreover, the nondiscrimination requirement does not meaningfully distinguish associations from insurance companies. DOL's nondiscrimination rule prohibits associations from discriminating against a member (for example, by charging it higher prices) based on a "health factor" of a member's employees. 83 Fed. Reg. at 28,926–27 & n.38. The rule does not prohibit discrimination based on other classifications. An association is thus free to charge different rates based on factors such as age, gender, industry, occupation, group size, or geography. 83 Fed. Reg. at 28,929 & nn.43, 44. The rule also does not prohibit an association from effectively discriminating against employees with health issues by designing benefit packages that

exclude their conditions, so long as the exclusion is not directed at specific employees. *Id.* at 28,927; *see also id.* at 28,963 (providing examples of permitted discrimination). And the rule does not prohibit associations from discriminating through their membership criteria as long as they specifically avoid conditioning membership on a health factor. *Id.* at 28,923.

In DOL's telling, the narrow nondiscrimination rule encourages "uniform treatment of members," which prevents associations from "too closely resembl[ing] medically-underwritten individual or small employer market commercial-type insurance coverage." 83 Fed. Reg. at 28,929. But that explanation ignores the fact that the ACA prohibits insurers in the individual and small-group market from engaging in medical underwriting. Instead, the ACA requires insurers to set prices based on adjusted community rating under which prices may vary only for type of coverage (individual or family), rating area (as established by a state), age (but no more than 3 to 1), and tobacco use. 42 U.S.C. § 300gg(a). Moreover, such insurers cannot discriminate against employees with health issues by skimping on required "essential health benefits," *id.* § 300gg-6(a), such as "[m]aternity and newborn care," "[m]ental health," "[p]rescription drugs," and "[p]ediatric services, including oral and vision care," *id.* § 18022(b)(1)(D), (E), (F), (J). And unlike associations, ACA-regulated

insurers must "accept every employer and individual in the State that applies for … coverage," *id.* § 300gg-1(a), a practice known as "guaranteed issue," *see King*, 135 S. Ct. at 2485.

Insurers in the individual and small-group market, thus, have less freedom to discriminate and must treat small businesses more uniformly than associations operating under DOL's rule. In these circumstances, DOL has failed to explain how the nondiscrimination requirement meaningfully distinguishes associations that are supposed to act in the interests of employers from "insurance-type arrangements, … whose purpose is … principally to identify and manage risk on a commercial basis." DOL Br. 9 (citing 83 Fed. Reg. at 28,929).

II. DOL misinterpreted Title XXVII of the PHS Act when it concluded that an association could count its members' employees as its own employees.

A. To get where it wanted to go, DOL could not stop at allowing employers to form larger, insurer-like associations. As DOL recognized, the "ACA imposes requirements in the individual and small group health insurance markets that do not apply in the large group market or to self-insured plans." 83 Fed. Reg. at 28,940. Because most associations do not self-insure, *id.* at 28,952, they must purchase health coverage from insurance companies operating in ACA-regulated insurance markets. DOL believed

that loosening its standard for bona fide associations would allow small businesses to combine into large groups capable of obtaining health coverage through the large-group market, rather than the markets for individuals or small-group market. *Id.* at 28,912.

The ACA's market definitions, however, do not fall within DOL's regulatory authority. Rather, they are contained within title XXVII of the PHS Act, which falls under HHS's purview. *See* 42 U.S.C. § 300gg-92. Under title XXVII, insurance is in the large-group or small-group market based on whether a group health plan is maintained by large or small employer. 42 U.S.C. §§ 300gg-91(e)(3), (5). And whether an employer is large or small is determined by counting the number of employees "employed" by the employer. *Id.* §§ 300gg-91(e)(2), (4). Title XXVII sets the threshold at 50 employees, *id.*, but allows states to adjust it to 100, *id.* § 300gg-91(e)(7). The individual market refers to non-group insurance, as well as to group health plans with fewer than two employees unless a state elects to place them in the small-group market. *Id.* § 300gg-91(e)(1). Title XXVII contains special rules for certain affiliated or commonly controlled employers, *id.* § 300gg-91(e)(6)(A), which permits "all employees" to be "treated as employed by a single employer," 26 U.S.C. §§ 414(b), (c), (m).

Title XXVII's definition of "employer" cross-references ERISA's definition. 42 U.S.C. § 300gg-91(d)(6). But title XXVII's detailed rules for counting employees does not expressly address insurance provided to group health plans established by associations. In 2011, the Center for Medicare and Medicaid Services (CMS), an agency within HHS, addressed that issue in a bulletin, explaining that "[a]ssociation coverage does not exist as a distinct category of health insurance coverage" under title XXVII. Memo. from Gary Cohen, Acting Director, Office of Oversight, CMS at 2 (Sept. 1, 2011) (CMS Bulletin) (JA___). CMS concluded that, in "most" situations, "the size of each individual employer participating in the association determines whether that employer's coverage is subject to the small group market or the large group market rules." *Id.* at 3. Nonetheless, CMS stated that, in "the rare instances" where an association is "deemed the 'employer'" and sponsors a single group health plan, "the number of employees employed by all of the employers participating in the association determines whether the coverage is subject to the small group market or the large group market rules." *Id.* CMS did not explain how this situation could be reconciled with title XXVII's requirement that the relevant health-insurance market should be determined by counting the number of employees "employed" by an employer.

B. Relying on the CMS Bulletin, DOL announced that "whether the AHP would be buying insurance in the large or small group market would be determined by reference to the total number of employees of all the member employers participating in the AHP." 83 Fed. Reg. at 28,915. This aggregation is the lynchpin of DOL's goal of enabling AHPs to be "treated as a single large group plan." *Id.* at 28,940. Yet it is inconsistent with title XXVII.

Title XXVII unambiguously looks to the number of employees "employed" by an employer to determine the relevant health-insurance market. And as DOL previously found, "the individuals typically covered by the group or association-sponsored plan are not 'employed' by the group or association and, therefore, are not 'employees' of the group or association."[2] In altering its view, DOL failed to "display awareness that it [was] changing position" and to "show that there are good reasons for the new policy." *See FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009). In failing even to attempt to reconcile its previous view that associations do not employ their

[2] DOL, Employee Benefits Security Admin., MEWAs: Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation 22 (Aug. 2013) (JA__).

members' employees with its new interpretation of title XXVII, DOL acted arbitrarily and capriciously.

Moreover, DOL cannot escape its obligation to engage in reasoned decisionmaking by relying on the CMS Bulletin, because the Bulletin itself lacked reasoning. CMS made "no 'reasonable attempt to grapple' with or even refer back to the statutory text" of title XXVII. *See BP Energy Co. v. FERC*, 828 F.3d 959, 965 (D.C. Cir. 2016) (quoting *Council for Urological Interests v. Burwell*, 790 F.3d 212, 223 (D.C. Cir. 2015)). CMS's "lack of specific attention to the statutory authorization" for the aggregation rule deprives it of any weight. *See Adamo Wrecking Co. v. United States*, 434 U.S. 275, 289 n.5 (1978); *see also Pub. Citizen, Inc. v. HHS*, 332 F.3d 654, 661 (D.C. Cir. 2003) ("Because the manual thus contains no reasoning that we can evaluate for its reasonableness, the high level of deference contemplated in *Chevron*'s second step is simply inapplicable.").

The CMS Bulletin was issued in 2011—seven years before DOL redefined "employer." The timing is important, because under DOL's longstanding standard for bona fide associations, *see* CMS Bulletin 3 n.6 (JA___), CMS reasonably understood that aggregation would result in association health plans purchasing insurance in only "rare instances," *id.* at 3. Nothing in the CMS Bulletin suggests that the employee-aggregation rule

is compelled by the text of title XXVII, so nothing prevents CMS from reaching a different conclusion if faced with DOL's new definition, which by design upends ACA-regulated health-insurance markets in a way that DOL's traditional standard did not. *See* Section III, *infra*.

DOL insists that the "final rule has been developed in consultation with" HHS. 83 Fed. Reg. at 28,915. But if HHS seeks to make fundamental changes to how health-care reform is implemented, it must proceed through notice-and-comment rulemaking, offering "genuine justifications for important decisions, reasons that can be scrutinized by courts and the interested public." *Dep't of Commerce*, 139 S. Ct. at 2575–76. HHS cannot evade its obligations under the Administrative Procedure Act by consulting with DOL behind the scenes. *See U.S. Telecom Ass'n v. FCC*, 359 F.3d 554, 566 (D.C. Cir. 2004) (stating that a federal agency "may not subdelegate [its decision-making authority] to outside entities—private or sovereign—absent affirmative evidence of authority to do so"). If it were allowed to do so, "lines of accountability may blur, undermining an important democratic check on government decision-making." *Id.* at 565. Here, Congress placed primary responsibility for implementing the ACA's insurance reforms with HHS, not DOL. If DOL is allowed to speak for HHS on this matter, no agency will be

accountable for the profound effects that DOL's rule will have on implementation of health-care reform under the ACA.

"[R]easonable statutory interpretation must account for both 'the specific context in which … language is used' and 'the broader context of the statute as a whole.'" *Util. Air Regulatory Grp. v. EPA*, 573 U.S. 302, 321 (2014) (quoting *Robinson v. Shell Oil Co.*, 519 U.S. 337, 341 (1997)). In this case, DOL has failed to reconcile the employee-aggregation rule with title XXVII's mandate that markets be defined by the number of employees "employed" by their employer. For that reason, the rule should be set aside.

III. DOL's new definition of "employer" impermissibly undermines the ACA's market reforms.

If this case were about nothing more than an agency making technical changes to its regulations, it would fail for lack of reasoned decisionmaking for the reasons stated above and in appellees' brief. But that is not all that this case is about. This case represents a concerted effort to upend statutorily required health-care reforms in favor of an approach more to the administration's liking. *See* Exec. Order No. 13,813, 82 Fed. Reg. 48,385 (Oct. 17, 2017). "What we have here, in reality, is a fundamental revision" to the ACA effected through rulemaking. *See MCI Telecomm. Corp. v. AT&T*, 512 U.S. 218, 231 (1994). Although the administration believes that is a "good idea," it is "not the idea Congress enacted into law." *Id.* at 232.

A. DOL's rule undermines the ACA's individual and small-group market reforms.

To "increase the number of Americans covered by health insurance and decrease the cost of health care," *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012), the ACA adopted certain reforms applicable to all markets for health-care coverage. These reforms include a ban on excluding individuals with "preexisting condition[s]," 42 U.S.C. § 300gg-3(a), and a requirement that all health insurers offer guaranteed issue and guaranteed renewal to any employer or individual seeking or renewing health insurance, *id.* §§ 300gg-1(a), 300gg-2(a).

Other reforms were targeted to individual and small-group markets, which "generally [were] viewed as dysfunctional" due to factors such as "lack of competition, adverse selection, and limited transparency." Notice of Proposed Rulemaking, Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, 77 Fed. Reg. 70,583, 70,587 (Nov. 26, 2012). DOL's rule is incompatible with the ACA's small-group and individual market reforms, and its attempt to create an end-run around the ACA will disproportionately harm women, families, and other communities that amici seek to serve.

1. In the ACA, Congress took several steps to protect vulnerable populations in the individual and small-group markets from discrimination

in health-care coverage and to enhance their ability to obtain comprehensive health-care coverage at lower prices. To protect against discrimination, Congress required insurers to cover essential health benefits and to use adjusted community rating when establishing prices for their insurance policies. *See* 42 U.S.C. §§ 300gg-6(a), 300gg(a); *see supra* p.12. These requirements help ensure coverage is available when patients need it, and they deter insurance companies from competing by designing benefit plans that exclude coverage for high-cost items like maternity and newborn care, prescription drugs or HIV treatment, and then using lower premiums to cherry-pick healthy individuals or groups. As amicus NPWF explained in its comments, in the individual market before the ACA, only 12 percent of individual-market plans covered maternity care, twenty percent of enrollees lacked prescription-drug coverage, and mental health was often excluded from coverage.[3] As Congress recognized, moreover, "historically, insurers have not covered medical services addressing a range of women's health needs." H.R. Rep. No. 111-299, pt. III, at 104 (2009). By mandating comprehensive coverage at adjusted-community-rated prices, Congress

[3] NPWF Comments at 4 (Mar. 6, 2018), https://www.regulations.gov/document?D=EBSA-2018-0001-0521.

sought to end these discriminatory practices in individual and small-group markets once and for all.

To make these reforms effective, Congress also did away with insurers' pre-ACA practice of "maintain[ing] several separate risk pools within their individual and small group market business, often as a way to segment risk and further underwrite premiums." 77 Fed. Reg. at 70,600. Congress understood that "broaden[ing] the health insurance risk pool to include healthy individuals" would "lower health insurance premiums." 42 U.S.C. § 18091(2)(I). The ACA, therefore, requires insurers in the individual and small-group markets to use a single risk pool for each market (or a merged risk pool if required by a state), *id.* § 18032(c), which is supported by a risk-adjustment mechanism to protect insurers and plans with high-actuarial risk, *id.* § 18063.

2. Whereas Congress contemplated unsegmented individual and small-group markets with insurers offering essential health benefits priced based on adjusted community rating, DOL's rule reintroduces segmentation into those markets and the discriminatory effects that go along with it. As DOL acknowledged, its rule gives associations of small businesses "regulatory flexibility to design more tailored, less comprehensive health coverage and set more actuarially fair prices that generally are lower for

lower risk groups and higher for higher risk ones." 83 Fed. Reg. at 28,939; *see also id.* at 28,939 n.73 (explaining that "actuarially fair" refers to coverage "priced so that the premium paid by an individual or business reflects the risks associated with insuring the particular individual or business"). DOL further acknowledged that "[t]his regulatory flexibility in design and pricing will necessarily lead to some favorable risk selection toward AHPs and adverse selection against individual and small group markets," *id.* at 28,939, because AHPs "can design health coverage to attract lower risk groups" away from those markets, *id.* at 28,944. What's more, an AHP may face pressure to "limit[] benefits in order to protect against adverse selection" from other AHPs that can use their "flexibility" to attract even lower-risk populations. *Id.* at 28,946.

DOL's restoration of adverse selection and risk-based pricing in individual and small-group markets "will lead to destructive segmentation of healthier from sicker people"[4]—an outcome that the ACA was designed to prevent. By incentivizing healthier groups to obtain association coverage, the "rule can be expected to increase premiums" in individual and small-group

[4] UHF Comments at 9, https://www.regulations.gov/document?D=EBSA-2018-0001-0543.

markets,[5] with some predicting percentage increases in the double digits, 83 Fed. Reg. at 28,945. Small businesses remaining in the individual or small-group markets "may see decreased choice" and "may even stop offering insurance to their employees" due to higher premiums or insurers leaving the market. *Id.* at 28,958; *see also id.* at 28,945 n.94 (noting "decimated market" in pre-ACA Kentucky when carriers left the state after AHPs were exempted from reforms).

At the same time, because associations may discriminate based on factors such as age, gender, industry, occupation, group size, or geography, *id.* at 28,929, any potential cost savings that associations may achieve from providing less comprehensive benefits may not be shared equally by all enrollees. In crafting the ACA, Congress cited a 2008 NWLC study that found widespread "'gender rating' where insurance companies arbitrarily charge women and men different rates" for insurance. H.R. Rep. No. 111-299, pt. III, at 92 n.102. The rulemaking record shows that DOL's rule risks a return to those days by, for example, allowing associations to design their plans "to be most affordable and attractive to categories of individuals with lower

[5] 83 Fed. Reg. at 28,949; *see also id.* at 28,948 ("premiums are likely to increase" in individual markets); *id.* at 28,950 (quoting U.S. Congressional Budget Office projection that premiums in those markets would be "2 percent to 3 percent higher in most years").

expected claims, such as young single men." 83 Fed. Reg. at 28,948; *see also id.* at 28,945 n.93 (explaining commenter's concern that "AHPs may rate men in their 20s more than 40 percent lower than would be consistent with individual and small group market rules, and may rate women in their late 20s and 30s more than 30 percent higher"). In much the same way, AHPs can "set premiums for newborns substantially higher than for older children," "split a state zone into smaller segments to reflect cost differences," or "set higher rates for smaller groups (of say, fewer than 10), and for women of child-bearing age." *Id.* at 28,945 n.90. None of these pricing differences would constitute discrimination on the basis of a health factor prohibited by DOL's nondiscrimination rule, but all would be unlawful if attempted by an ACA-regulated insurer operating in individual and small-group markets.

The less comprehensive coverage that makes association health plans less expensive also "puts the economic stability and health of plan participants and their beneficiaries at risk by allowing employers to offer limited coverage that fails to meet the needs of their employees."[6] As amicus Families USA explained in its comments, the ACA ensures that "children now

[6] NELP Comments at 5, https://www.regulations.gov/document?D=EBSA-2018-0001-0469.

get both preventive dental care and needed fillings and restorative care," which helps them "maintain health, avoid pain, and impacts their school performance."[7] Amicus NPWF likewise warned that if an employee covered by an AHP "later develops a health condition such as cancer or HIV, or requires hospitalization," the employee may not be covered, whereas he or she would have coverage under the ACA.[8] And as amicus NWLC explained, "when plans have discretion to set benefit categories, coverage that is vital for women, like maternity care, is often what is eliminated," and by circumventing the ACA's essential health benefits requirement, the rule "could send women back to the days before the ACA, when plans frequently failed to meet their important health needs."[9] Besides the obvious health

[7] Families USA Comments at 2 (Mar. 6, 2018), https://www.regulations.gov/document?D=EBSA-2018-0001-0526.

[8] NPWF Comments at 4 (Mar. 6, 2018), https://www.regulations.gov/document?D=EBSA-2018-0001-0521.

[9] NWLC Comments at 2 (Mar. 6, 2018), https://www.regulations.gov/document?D=EBSA-2018-0001-0652 (citing NWLC, Nowhere to Turn: How the Individual Health Insurance Market Fails Women (June 2008), https://nwlc.org/wp-content/uploads/2015/08/NWLCReport-NowhereToTurn-81309w.pdf).

effects, inadequate coverage "will also drive up medical debt and health-related bankruptcies, which have ameliorated since the ACA was enacted."[10]

B. Associations under DOL's new rule are not comparable to large employers.

DOL disagrees with Congress's decision to place small businesses in individual and small-group markets, and it sees associations as a vehicle for bootstrapping them into the large-group market.[11] But Congress treated large employers differently because of real-world differences between employers who employ a large number of people and those who do not. In particular, large employers have a primary purpose other than providing health insurance to their employees. Associations under DOL's new rule, by contrast, can form for the primary purpose of providing health insurance to members' employees. Accordingly, "AHPs generally will have incentives to tailor benefits to appeal to lower-risk groups—an incentive that large employers generally do not share." 83 Fed. Reg. at 28,941.

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[10] NHeLP Comments at 4–5, https://www.regulations.gov/document?D=EBSA-2018-0001-0496.

[11] *See* 83 Fed Reg. at 28,912 ("By participating in AHPs, employees of small employers and working owners are able to obtain coverage that is not subject to the regulatory complexity and burden that currently characterizes the market for individual and small group health coverage and, therefore, can enjoy flexibility with respect to benefit package design comparable to that enjoyed by large employers.").

Specifically, true employers "design and price health benefit offers to recruit and retain productive workers and to maximize those workers' productivity" and thus "offer heavily subsidized comprehensive health coverage." *Id.* at 28,944. Associations, however, compete "with more heavily regulated individual and small group issuers, and possibly with one another," incentivizing "pricing and benefits [that] will attract favorable risk pools and facilitate lower premiums." *Id.*; *see also id.* at 28,945 n.94 (noting a commenter's "concerns that AHPs cannot duplicate large employers' advantages with respect to the composition and stability of risk pools"). In other words, associations of small businesses will exhibit the very same characteristics that led Congress to adopt individual and small-group market reforms in the ACA.

Similar economic differences exist for health plans that self-insure rather than obtain coverage in the large-group market. Many large employers self-insure. *Id.* at 28,940. An association that self-insures, however, has "more operational risk than self-insured large employers" because the "AHP is more exposed to unanticipated favorable or adverse selection" and, unlike a large employer, cannot "tap other revenue sources to cover claims volatility." *Id.* at 28,943 n.87. As a result, "[s]ome self-insured AHPs historically have subjected consumers to fraud, mismanagement, and

abuse." *Id.* at 28,954 n.142; *see also id.* at 28,917 (noting commenters' observation that self-insured AHPs were "ripe for abuse"); FamiliesUSA Comments at 1 (same); NPWF Comments at 2 (same). Indeed, the profound differences in financial incentives between self-insured AHPs and self-insured large employers has led Congress to amend ERISA so that states may regulate AHPs (but not large employers) as insurance companies. *See* 83 Fed. Reg. at 28,937; 29 U.S.C. § 1144(b)(6). Therefore, even self-insuring associations are not economically analogous to large employers in the health-coverage market.

* * * * *

In the ACA, Congress tackled the difficult problem of lowering the cost of health insurance while preserving patient protections and ensuring that the elderly, women, individuals with disabilities, and others have access to the coverage and care that they need on a nondiscriminatory basis. In its rule, DOL replaced Congress's plan with one of its own, fully aware that its plan would bring back "the type of calamitous result that Congress plainly meant to avoid." *King*, 135 S. Ct. at 2496. Whatever leeway DOL has to reinterpret the meaning of "employer" in ERISA, Congress has not delegated to DOL the power to "undo what [Congress] has done." *Id.*

CONCLUSION

This Court should affirm the judgment of the district court.

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Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing Brief for Amici Curiae in Support of Appellees and Affirmance complies with the type-volume limitations of FRAP 32(a)(7)(B) and 29(d). The brief is composed in a 14-point proportional typeface, Georgia. As calculated by my word processing software (Microsoft Word 365), the brief (excluding those parts permitted to be excluded under the Federal Rules of Appellate Procedure and this Court's rules) contains 6,041 words.

/s/ Nandan M. Joshi
Nandan M. Joshi

STATUTORY AND REGULATORY APPENDIX

42 U.S.C. § 300gg-1(a).....A-1

42 U.S.C. § 300gg-2(a) A-2

42 U.S.C. § 300gg-3(a) A-3

42 U.S.C. § 300gg-92..... A-4

42 U.S.C. § 18063 .....A-5

42 U.S.C. § 18091(2)(I).....A-7

ices to provide for a study on the effectiveness of the provisions of title I of Pub. L. 104–191 and the various State laws, in ensuring the availability of reasonably priced health coverage to employers and individuals and a study on access to, and choice of, health care providers and the cost and cost-effectiveness to health insurance issuers of providing access to out-of-network providers, and the potential impact of providing such access on the cost and quality of health insurance coverage, and to report to the appropriate committees of Congress on each of such studies not later than Jan. 1, 2000.

§ 300gg–1. Guaranteed availability of coverage

(a) Guaranteed issuance of coverage in the individual and group market

Subject to subsections (b) through (e),[1] each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

(b) Enrollment

(1) Restriction

A health insurance issuer described in subsection (a) may restrict enrollment in cov-erage described in such subsection to open or special enrollment periods.

(2) Establishment

A health insurance issuer described in subsection (a) shall, in accordance with the regu-lations promulgated under paragraph (3), es-tablish special enrollment periods for qualify-ing events (under section 1163 of title 29).

(3) Regulations

The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).

(c) Special rules for network plans

(1) In general

In the case of a health insurance issuer that offers health insurance coverage in the group and individual market through a network plan, the issuer may—

(A) limit the employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and

(B) within the service area of such plan, deny such coverage to such employers and individuals if the issuer has demonstrated, if required, to the applicable State authority that—

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups or any additional individuals because of its obligations to existing group contract holders and enrollees, and

(ii) it is applying this paragraph uniformly to all employers and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals[1] employees and dependents.

(2) 180-day suspension upon denial of coverage

An issuer, upon denying health insurance coverage in any service area in accordance with paragraph (1)(B), may not offer coverage in the group or individual market within such service area for a period of 180 days after the date such coverage is denied.

(d) Application of financial capacity limits

(1) In general

A health insurance issuer may deny health insurance coverage in the group or individual market if the issuer has demonstrated, if required, to the applicable State authority that—

(A) it does not have the financial reserves necessary to underwrite additional coverage; and

(B) it is applying this paragraph uniformly to all employers and individuals in the group or individual market in the State consistent with applicable State law and without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals, employees and dependents.

(2) 180-day suspension upon denial of coverage

A health insurance issuer upon denying health insurance coverage in connection with group health plans in accordance with paragraph (1) in a State may not offer coverage in connection with group health plans in the group or individual market in the State for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated to the applicable State authority, if required under applicable State law, that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. An applicable State authority may provide for the application of this subsection on a service-area-specific basis.

(July 1, 1944, ch. 373, title XXVII, § 2702, as added and amended Pub. L. 111–148, title I, §§ 1201(4), 1563(c)(8), formerly § 1562(c)(8), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 156, 266, 911.)

CODIFICATION

The text of section 300gg–11 of this title, which was amended and transferred to subsecs. (c) and (d) of this section by Pub. L. 111–148, § 1563(c)(8), formerly § 1562(c)(8), as renumbered by Pub. L. 111–148, § 10107(b)(1), was based on act July 1, 1944, ch. 373, title XXVII, § 2731, formerly § 2711, as added Pub. L. 104–191, title I, § 102(a), Aug. 21, 1996, 110 Stat. 1962; renumbered § 2731, Pub. L. 111–148, title I, § 1001(3), Mar. 23, 2010, 124 Stat. 130.

PRIOR PROVISIONS

A prior section 300gg–1, act July 1, 1944, ch. 373, title XXVII, § 2702, as added Pub. L. 104–191, title I, § 102(a), Aug. 21, 1996, 110 Stat. 1961; Pub. L. 110–233, title I, § 102(a)(1)–(3), May 21, 2008, 122 Stat. 888, 890, which related to prohibition on discrimination against individual participants and beneficiaries based on health status, was amended by Pub. L. 111–148, title I, § 1201(3), Mar. 23, 2010, 124 Stat. 154, effective for plan years beginning on or after Jan. 1, 2014, and was transferred to subsecs. (b) to (f) of section 300gg–4 of this title.

Another prior section 2702 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238a of this title.

[1] So in original.

AMENDMENTS

2010—Pub. L. 111–148, § 1563(c)(8), formerly § 1562(c)(8), as renumbered by Pub. L. 111–148, § 10107(b)(1), transferred section 300gg–11 of this title to the end of this section after amending it by striking out the section catchline ''Guaranteed availability of coverage for employers in group market'', by striking out subsec. (a) which related to issuance of coverage in small group market, subsec. (b) which related to assurance of access in large group market, subsec. (e) which related to exception to requirement for failure to meet certain minimum participation or contribution rules, and subsec. (f) which related to exception for coverage offered only to bona fide association members, by amending subsec. (c) by substituting ''group and individual'' for ''small group'' in introductory provisions of par. (1), inserting ''and individuals'' after ''employers'' in introductory provisions of par. (1)(B), inserting ''or any additional individuals'' after ''additional groups'' in par. (1)(B)(i), substituting ''and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals'' for ''without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such'' in par. (1)(B)(ii), and substituting ''group or individual'' for ''small group'' in par. (2), and by amending subsec. (d) by substituting ''group or individual'' for ''small group'' wherever appearing and substituting ''all employers and individuals'' for ''all employers'', ''those individuals, employers'' for ''those employers'', and ''such individuals, employees'' for ''such employees'' in par. (1)(B).

EFFECTIVE DATE

Section effective for plan years beginning on or after Jan. 1, 2014, see section 1255 of Pub. L. 111–148, set out as a note under section 300gg of this title.

§ 300gg–2. Guaranteed renewability of coverage

(a) In general

Except as provided in this section, if a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.

(b) General exceptions

A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a health insurance coverage offered in the group or individual market based only on one or more of the following:

(1) Nonpayment of premiums

The plan sponsor, or individual, as applicable, has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.

(2) Fraud

The plan sponsor, or individual, as applicable, has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) Violation of participation or contribution rates

In the case of a group health plan, the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, pursuant to applicable State law.

(4) Termination of coverage

The issuer is ceasing to offer coverage in such market in accordance with subsection (c) and applicable State law.

(5) Movement outside service area

In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business) and, in the case of the small group market, the issuer would deny enrollment with respect to such plan under section 2711(c)(1)(A).[1]

(6) Association membership ceases

In the case of health insurance coverage that is made available in the small or large group market (as the case may be) only through one or more bona fide associations, the membership of an employer in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual.

(c) Requirements for uniform termination of coverage

(1) Particular type of coverage not offered

In any case in which an issuer decides to discontinue offering a particular type of group or individual health insurance coverage, coverage of such type may be discontinued by the issuer in accordance with applicable State law in such market only if—

(A) the issuer provides notice to each plan sponsor or individual, as applicable, provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

(B) the issuer offers to each plan sponsor or individual, as applicable, provided coverage of this type in such market, the option to purchase all (or, in the case of the large group market, any) other health insurance coverage currently being offered by the issuer to a group health plan or individual health insurance coverage in such market; and

(C) in exercising the option to discontinue coverage of this type and in offering the option of coverage under subparagraph (B), the issuer acts uniformly without regard to the claims experience of those sponsors or individuals, as applicable, or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

(2) Discontinuance of all coverage

(A) In general

In any case in which a health insurance issuer elects to discontinue offering all health

[1] See References in Text note below.

insurance coverage in the individual or group market, or all markets, in a State, health insurance coverage may be discontinued by the issuer only in accordance with applicable State law and if—

(i) the issuer provides notice to the applicable State authority and to each plan sponsor or individual, as applicable,[2] (and participants and beneficiaries covered under such coverage) of such discontinuation at least 180 days prior to the date of the discontinuation of such coverage; and

(ii) all health insurance issued or delivered for issuance in the State in such market (or markets) are discontinued and coverage under such health insurance coverage in such market (or markets) is not renewed.

(B) Prohibition on market reentry

In the case of a discontinuation under subparagraph (A) in a market, the issuer may not provide for the issuance of any health insurance coverage in the market and State involved during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) Exception for uniform modification of coverage

At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan—

(1) in the large group market; or

(2) in the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, such modification is consistent with State law and effective on a uniform basis among group health plans with that product.

(e) Application to coverage offered only through associations

In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more associations, a reference to ''plan sponsor'' is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

(July 1, 1944, ch. 373, title XXVII, § 2703, as added and amended Pub. L. 111–148, title I, §§ 1201(4), 1563(c)(9), formerly § 1562(c)(9), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 156, 267, 911.)

REFERENCES IN TEXT

Section 2711, referred to in subsec. (b)(5), is a reference to section 2711 of act July 1, 1944. Section 2711, which was classified to section 300gg–11 of this title, was renumbered section 2731 and amended and transferred by Pub. L. 111–148, title I, §§ 1001(3), 1563(c)(8), formerly § 1562(c)(8), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 266, 911, to the end of section 2702 of act July 1, 1944, as added by Pub. L. 111–148, title I, § 1201(4), Mar. 23, 2010, 124 Stat. 156, and classified to section 300gg–1 of this title. A new section 2711 of act July 1, 1944, related to no lifetime or annual limits, was added by Pub. L. 111–148, title I, § 1001(5), Mar. 23, 2010, 124 Stat. 131, effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, and is classified to section 300gg–11 of this title.

CODIFICATION

The text of section 300gg–12 of this title, which was amended and transferred to subsecs. (b) to (e) of this section by Pub. L. 111–148, § 1563(c)(9), formerly § 1562(c)(9), as renumbered by Pub. L. 111–148, § 10107(b)(1), was based on act July 1, 1944, ch. 373, title XXVII, § 2732, formerly § 2712, as added Pub. L. 104–191, title I, § 102(a), Aug. 21, 1996, 110 Stat. 1964; renumbered § 2732, Pub. L. 111–148, title I, § 1001(3), Mar. 23, 2010, 124 Stat. 130.

PRIOR PROVISIONS

A prior section 2703 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238b of this title.

AMENDMENTS

2010—Pub. L. 111–148, § 1563(c)(9), formerly § 1562(c)(9), as renumbered by Pub. L. 111–148, § 10107(b)(1), transferred section 300gg–12 of this title to the end of this section after amending it by striking out the section catchline ''Guaranteed renewability of coverage for employers in group market'', by striking subsec. (a) which required a health insurance issuer offering coverage in connection with a group health plan to renew such coverage at the option of the plan sponsor, by amending subsec. (b) by substituting ''health insurance coverage offered in the group or individual market'' for ''group health plan in the small or large group market'' in introductory provisions, inserting '', or individual, as applicable,'' after ''plan sponsor'' in pars. (1) and (2), adding par. (3), and striking out former par. (3) which related to violation of participation or contribution rules, and by amending subsec. (c) by substituting ''group or individual health insurance coverage'' for ''group health insurance coverage offered in the small or large group market'' in introductory provisions of par. (1), inserting ''or individual, as applicable,'' after ''plan sponsor'' in par. (1)(A) and (B), inserting ''or individual health insurance coverage'' in par. (1)(B), inserting ''or individuals, as applicable,'' after ''those sponsors'' in par. (1)(C), substituting ''individual or group market, or all markets,'' for ''small group market or the large group market, or both markets,'' in introductory provisions of par. (2)(A), and inserting ''or individual, as applicable,'' after ''plan sponsor'' in par. (2)(A)(i). Amendment inserting ''or individual health insurance coverage'' in subsec. (c)(1)(B) was executed by making the insertion after ''group health plan'' as the probable intent of Congress, notwithstanding that the directory language did not specify where in subsec. (c)(1)(B) to make the insertion.

EFFECTIVE DATE

Section effective for plan years beginning on or after Jan. 1, 2014, see section 1255 of Pub. L. 111–148, set out as a note under section 300gg of this title.

§ 300gg–3. Prohibition of preexisting condition exclusions or other discrimination based on health status

(a) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.

(b) Definitions

For purposes of this part—

(1) Preexisting condition exclusion

(A) In general

The term ''preexisting condition exclusion'' means, with respect to coverage, a

[2] So in original.

Subsec. (e)(4). Pub. L. 111–148, § 1563(c)(16)(B), formerly § 1562(c)(16)(B), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''100'' for ''50'' and ''at least 1'' for ''at least 2'' in two places.

2008—Subsec. (d)(15) to (19). Pub. L. 110–233 added pars. (15) to (19).

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by Pub. L. 114–255 applicable to plan years beginning after Dec. 31, 2016, see section 18001(c)(3) of Pub. L. 114–255, set out as a note under section 300bb–8 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–233 applicable, with respect to group health plans and health insurance coverage offered in connection with group health plans, for plan years beginning after the date that is one year after May 21, 2008, and, with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market, after the date that is one year after May 21, 2008, see section 102(d)(2) of Pub. L. 110–233, set out as a note under section 300gg–21 of this title.

§ 300gg–92. Regulations

The Secretary, consistent with section 104 of the Health Care Portability and Accountability Act of 1996, may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this subchapter. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this subchapter.

(July 1, 1944, ch. 373, title XXVII, § 2792, as added Pub. L. 104–191, title I, § 102(a), Aug. 21, 1996, 110 Stat. 1976.)

REFERENCES IN TEXT

Section 104 of the Health Care Portability and Accountability Act of 1996, referred to in text, probably means section 104 of the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191, set out below.

ASSURING COORDINATION AMONG DEPARTMENTS OF TREASURY, HEALTH AND HUMAN SERVICES, AND LABOR

Pub. L. 104–191, title I, § 104, Aug. 21, 1996, 110 Stat. 1978, provided that: ''The Secretary of the Treasury, the Secretary of Health and Human Services, and the Secretary of Labor shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

''(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under this subtitle [subtitle A (§§ 101–104) of title I of Pub. L. 104–191, enacting this section, sections 300gg, 300gg–1, 300gg–11 to 300gg–13, 300gg–21 to 300gg–23, and 300gg–91 of this title, and sections 1181 to 1183 and 1191 to 1191c of Title 29, Labor, amending sections 300e and 300bb–8 of this title and sections 1003, 1021, 1022, 1024, 1132, 1136, and 1144 of Title 29, and enacting provisions set out as notes under section 300gg of this title and section 1181 of Title 29] (and the amendments made by this subtitle and section 401 [enacting sections 9801 to 9806 of Title 26, Internal Revenue Code]) are administered so as to have the same effect at all times; and

''(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.''

§ 300gg–93. Health insurance consumer information

(a) In general

The Secretary shall award grants to States to enable such States (or the Exchanges operating in such States) to establish, expand, or provide support for—

(1) offices of health insurance consumer assistance; or

(2) health insurance ombudsman programs.

(b) Eligibility

(1) In general

To be eligible to receive a grant, a State shall designate an independent office of health insurance consumer assistance, or an ombudsman, that, directly or in coordination with State health insurance regulators and consumer assistance organizations, receives and responds to inquiries and complaints concerning health insurance coverage with respect to Federal health insurance requirements and under State law.

(2) Criteria

A State that receives a grant under this section shall comply with criteria established by the Secretary for carrying out activities under such grant.

(c) Duties

The office of health insurance consumer assistance or health insurance ombudsman shall—

(1) assist with the filing of complaints and appeals, including filing appeals with the internal appeal or grievance process of the group health plan or health insurance issuer involved and providing information about the external appeal process;

(2) collect, track, and quantify problems and inquiries encountered by consumers;

(3) educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage;

(4) assist consumers with enrollment in a group health plan or health insurance coverage by providing information, referral, and assistance; and

(5) resolve problems with obtaining premium tax credits under section 36B of title 26.

(d) Data collection

As a condition of receiving a grant under subsection (a), an office of health insurance consumer assistance or ombudsman program shall be required to collect and report data to the Secretary on the types of problems and inquiries encountered by consumers. The Secretary shall utilize such data to identify areas where more enforcement action is necessary and shall share such information with State insurance regulators, the Secretary of Labor, and the Secretary of the Treasury for use in the enforcement activities of such agencies.

(e) Funding

(1) Initial funding

There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $30,000,000 for the first fiscal year for which this section applies to

signed to implement the reinsurance program.

(2) State discretion

A State may have more than 1 applicable reinsurance entity to carry out the reinsurance program under this section within the State and 2 or more States may enter into agreements to provide for an applicable reinsurance entity to carry out such program in all such States.

(3) Entities are tax-exempt

An applicable reinsurance entity established under this section shall be exempt from taxation under chapter 1 of title 26. The preceding sentence shall not apply to the tax imposed by section 511 such [3] title (relating to tax on unrelated business taxable income of an exempt organization).

(d) Coordination with State high-risk pools

The State shall eliminate or modify any State high-risk pool to the extent necessary to carry out the reinsurance program established under this section. The State may coordinate the State high-risk pool with such program to the extent not inconsistent with the provisions of this section.

(Pub. L. 111–148, title I, § 1341, title X, § 10104(r), Mar. 23, 2010, 124 Stat. 208, 906.)

AMENDMENTS

2010—Pub. L. 111–148, § 10104(r)(1), substituted ''market'' for ''and small group markets'' in section catchline.

Subsec. (b)(2)(B). Pub. L. 111–148, § 10104(r)(2), substituted ''paragraph (1)(B)'' for ''paragraph (1)(A)'' in introductory provisions.

Subsec. (c)(1)(A). Pub. L. 111–148, § 10104(r)(3), substituted ''individual market'' for ''individual and small group markets''.

§ 18062. Establishment of risk corridors for plans in individual and small group markets

(a) In general

The Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.].

(b) Payment methodology

(1) Payments out

The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and

(B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

(2) Payments in

The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and

(B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

(c) Definitions

In this section:

(1) Allowable costs

(A) In general

The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.

(B) Reduction for risk adjustment and reinsurance payments

Allowable costs shall [1] reduced by any risk adjustment and reinsurance payments received under section [2] 18061 and 18063 of this title.

(2) Target amount

The target amount of a plan for any year is an amount equal to the total premiums (including any premium subsidies under any governmental program), reduced by the administrative costs of the plan.

(Pub. L. 111–148, title I, § 1342, Mar. 23, 2010, 124 Stat. 211.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (a), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Part D of title XVIII of the Act is classified generally to part D (§ 1395w–101 et seq.) of subchapter XVIII of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

§ 18063. Risk adjustment

(a) In general

(1) Low actuarial risk plans

Using the criteria and methods developed under subsection (b), each State shall assess a charge on health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actu-

[3] So in original. Probably should be preceded by ''of''.

[1] So in original. Probably should be followed by ''be''.

[2] So in original. Probably should be ''sections''.

arial risk of all enrollees in all plans or coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1001 et seq.]).

(2) High actuarial risk plans

Using the criteria and methods developed under subsection (b), each State shall provide a payment to health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

(b) Criteria and methods

The Secretary, in consultation with States, shall establish criteria and methods to be used in carrying out the risk adjustment activities under this section. The Secretary may utilize criteria and methods similar to the criteria and methods utilized under part C or D of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq., 1395w–101 et seq.]. Such criteria and methods shall be included in the standards and requirements the Secretary prescribes under section 18041 of this title.

(c) Scope

A health plan or a health insurance issuer is described in this subsection if such health plan or health insurance issuer provides coverage in the individual or small group market within the State. This subsection shall not apply to a grandfathered health plan or the issuer of a grandfathered health plan with respect to that plan.

(Pub. L. 111–148, title I, §1343, Mar. 23, 2010, 124 Stat. 212.)

REFERENCES IN TEXT

The Employee Retirement Income Security Act of 1974, referred to in subsec. (a), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 829, which is classified principally to chapter 18 (§1001 et seq.) of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

The Social Security Act, referred to in subsec. (b), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Parts C and D of title XVIII of the Act are classified generally to parts C (§1395w–21 et seq.) and D (§1395w–101 et seq.), respectively, of subchapter XVIII of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

SUBCHAPTER IV—AFFORDABLE COVERAGE CHOICES FOR ALL AMERICANS

PART A—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

§18071. Reduced cost-sharing for individuals enrolling in qualified health plans

(a) In general

In the case of an eligible insured enrolled in a qualified health plan—

(1) the Secretary shall notify the issuer of the plan of such eligibility; and

(2) the issuer shall reduce the cost-sharing under the plan at the level and in the manner specified in subsection (c).

(b) Eligible insured

In this section, the term ''eligible insured'' means an individual—

(1) who enrolls in a qualified health plan in the silver level of coverage in the individual market offered through an Exchange; and

(2) whose household income exceeds 100 percent but does not exceed 400 percent of the poverty line for a family of the size involved.

In the case of an individual described in section 36B(c)(1)(B) of title 26, the individual shall be treated as having household income equal to 100 percent for purposes of applying this section.

(c) Determination of reduction in cost-sharing

(1) Reduction in out-of-pocket limit

(A) In general

The reduction in cost-sharing under this subsection shall first be achieved by reducing the applicable out-of pocket[1] limit under section 18022(c)(1) of this title in the case of—

(i) an eligible insured whose household income is more than 100 percent but not more than 200 percent of the poverty line for a family of the size involved, by two-thirds;

(ii) an eligible insured whose household income is more than 200 percent but not more than 300 percent of the poverty line for a family of the size involved, by one-half; and

(iii) an eligible insured whose household income is more than 300 percent but not more than 400 percent of the poverty line for a family of the size involved, by one-third.

(B) Coordination with actuarial value limits

(i) In general

The Secretary shall ensure the reduction under this paragraph shall not result in an increase in the plan's share of the total allowed costs of benefits provided under the plan above—

(I) 94 percent in the case of an eligible insured described in paragraph (2)(A);

(II) 87 percent in the case of an eligible insured described in paragraph (2)(B);

(III) 73 percent in the case of an eligible insured whose household income is more than 200 percent but not more than 250 percent of the poverty line for a family of the size involved; and

(IV) 70 percent in the case of an eligible insured whose household income is more than 250 percent but not more than 400 percent of the poverty line for a family of the size involved.

(ii) Adjustment

The Secretary shall adjust the out-of pocket[1] limits under paragraph (1) if nec-

[1] So in original. Probably should be ''out-of-pocket''.

taken into account as income and shall not be taken into account as resources for the month of receipt and the following 2 months; and

(2) any cost-sharing reduction payment or advance payment of the credit allowed under such section 36B that is made under section 18071 or 18082 of this title shall be treated as made to the qualified health plan in which an individual is enrolled and not to that individual.

(Pub. L. 111–148, title I, §1415, Mar. 23, 2010, 124 Stat. 237.)

REFERENCES IN TEXT

Section 1401, referred to in par. (1), means section 1401 of Pub. L. 111–148.

SUBCHAPTER V—SHARED RESPONSIBILITY FOR HEALTH CARE

PART A—INDIVIDUAL RESPONSIBILITY

§ 18091. Requirement to maintain minimum essential coverage; findings

Congress makes the following findings:

(1) In general

The individual responsibility requirement provided for in this section (in this section referred to as the ''requirement'') is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(2) Effects on the national economy and interstate commerce

The effects described in this paragraph are the following:

(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased. In the absence of the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019. Private health insurance spending is projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured.

(D) The requirement achieves near-univer-sal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

(E) The economy loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce this economic cost.

(F) The cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over $1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

(G) 62 percent of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(H) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

(I) Under sections 2704 and 2705 of the Public Health Service Act [42 U.S.C. 300gg–3, 300gg–4] (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

(J) Administrative costs for private health insurance, which were $90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential

CERTIFICATE OF SERVICE

I hereby certify that, on July 22, 2019, this Brief for Amici Curiae in Support of Appellees and Affirmance was served through the Court's ECF system on counsel for all parties.

/s/ Nandan M. Joshi
Nandan M. Joshi